Patient: ____ D.O.B.:______________

INTAKE SUMMARY

Staff: ____

Date of Contacts: ____

Date Transcribed: ____

PATIENT'S REQUEST(S):

OVERALL GOAL:

FAMILY AND SOCIAL HISTORY:
Home Environment:

Family Relationships/Participation of Significant Others:

Peer group/Social Support/Spiritual Support:

EDUCATION/WORK/FINANCIAL HISTORY:
Education:

Work History:

Current Means of Financial Support:

Insurance source:

Veteran status:

MEDICAL:
Current Visual Status and History:

Current Medical Status and History:

Previous OT (w/in past year):

Mini Mental Health Assessment: (Please include statements relating to patient's appearance, mood, affect, orientation, and thought processes. Other mental health areas may be addressed if needed.)

ADDITIONAL SIGNIFICANT HISTORY OR INFORMATION:

Client Education on Driving and Alternate Forms of Transportation:

REFERRALS AND RECOMMENDATIONS:

Signature ___________________________________ **Date**_____________________
Social Worker